Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 12, 2020	2020_548756_0010	002756-20	Complaint

Licensee/Titulaire de permis

Broadview Nursing Centre Limited
210 Brockville Street Smiths Falls ON K7A 3Z4

Long-Term Care Home/Foyer de soins de longue durée

Broadview Nursing Centre
210 Brockville Street Smiths Falls ON K7A 3Z4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA CUMMINGS (756)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 9, 10, 11, 12, and July 22, 2020

Log #002756-20: A complaint related to the provision of resident care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), a Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), a Physiotherapist (PT), Maintenance staff, and several residents.

During the course of the inspection, the inspector reviewed several resident healthcare records, observed resident rooms and equipment, observed several resident bed systems, and reviewed the licensee policy #E-05 'Bed Rails', last updated April 24, 2019.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

In March 2019, the Ministry of Long-Term Care (MLTC) issued a memo to all Long-Term Care Home Administrators to clarify the requirements and expectations around the proper use of bed rails. The memo directed the licensee's to the memo sent in August 2012 advising them to use the Health Canada Guideline (HCG) "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" as a guiding best practice document. The HCG document includes two additional companion documents which outline prevailing practices related to the use of bed rails. One of the companion documents is a clinical practice guideline, titled 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003' (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's healthcare record, and approval by the team if bed rails are to be used.

Through interviews, ADOC #102, RPN #106 and PT #112 were identified as the members of the interdisciplinary team who complete resident assessments, including a risk/benefit assessment, and approve the use of bed rails.

On a specified day, ADOC #102 documented in resident #001's healthcare record that a specified number of bed rails would be installed on the resident's bed system the following day. On the following day, resident #001 was observed to have the specified number of bed rails applied to their bed system that were in use and in the up position.

When interviewed on a specified day, RPN #106 and PT #112 both confirmed that they did not take part in the resident assessment and approval for the initiation of bed rails for resident #001 on this day. ADOC #102 confirmed that they alone assessed the resident, completed the risk-benefit assessment and approved the use of bedrails for the resident.

In summary, it was determined that the resident assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document as it was not conducted by the interdisciplinary team. [s. 15. (1) (a)]

Issued on this 17th day of August, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.